STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155697	A. BUILDING 00 B. WING	11/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLARK REHABILITATION AND SKILLED NURSING CENTER	517 N LITTLE LEAGUE BLVD CLARKSVILLE, IN47129

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F0000	This visit was for Investigation of Complaint IN00099666. Complaint IN00099666 - Substantiated. Federal/state deficiencies related to the allegations are cited at F156, F159, and F242. Survey date: 11/15/11 Facility number: 000059 Provider number: 155697 AIM number: 100266560 Survey team: Jennie Bartelt, RN Census bed type: SNF: 9 SNF/NF: 54 Total: 63 Census payor type: Medicare: 8 Medicaid: 45 Other: 10 Total: 63 Sample: 14 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2.	F0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a Desk review on or after **December 2, 2012.**	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Quality review completed on November 18, 2011 by Bev Faulkner, RN			

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F0156 SS=E	The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section;			

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	A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law.			

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	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. Based on record review, observation and interview, the facility failed to ensure residents were informed clearly in writing when the facility's rule related to smoking times was changed. The deficient practice affected 11 of 11 residents identified as smokers in a sample of 14. (Residents B, C, D, H, I, J, K, L, M, N, and O) Resident E was interviewed related to notification about rule changes. Findings include: On 11/15/11 at 11:15 a.m., the Director of Nursing Services provided a list of facility residents who were interviewable. Review of the list indicated the following residents were interviewable: Residents B, D, and E. During observation in the dining room on 11/15/11 at 12:50 p.m., a sign was observed posted at the doorway leading to the facility's fenced patio with smoking	F0156	**F 156 Notice of Rights, Rules, Services, Charges** It is the practice of this provider to ensure all residents are made aware of any policy changes with the required thirty day notification prior to implementation. **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · Residents B, C, D, H, I, J, K, L, M, N and O received written communication verifying current smoking times by the Executive Director and the Social Services director on 11/22-11/23/11. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All new policies will be	11/23/2011

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	hut. Review of the sign indicated, "Smoking Times are at these times only: 8:30 a.m., 1:30 p.m., 6:30 p.m., and 10:30 p.m. Each resident will receive two cigarettes only and must wear a smoking apron...." Resident H was at the door and indicated she wanted to go outside to await the next smoking time. The Social Services Director (SSD) assisted Resident H to go out the door. During interview at this time, the SSD indicated the smoking times recently had been changed and "cut back" from "eight times to four times" a day. The SSD indicated she went to Resident Council in September 2011 to announce the new smoking schedule. She indicated residents were "running out [of cigarettes] at the end of the month." During observation and interviews completed on 11/15/11 at 1:45 p.m., in the facility's smoking hut, seven residents were observed wearing smoking aprons and smoking cigarettes. The residents were supervised by the Activities Assistant. Resident B indicated the number of smoking times had decreased from eight to four times per day since he was admitted to the facility. Resident B indicated some residents did not get to smoke at the 10:30 p.m. smoke break because they were already in bed. Resident B indicated those residents really only had three smoking breaks. Resident		reviewed by Executive Director prior to implementation to ensure residents receive at least a thirty day notice prior to implementation. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · Admission packets have been updated with the current smoking times to ensure all future residents are aware of the correct times. · All additional residents currently listed as actively smoking received communication from the Executive Director and the Social Services Director on 11/22-11/23/11 verifying they are aware of the change in smoking times that took affect in October, 2011. · All alert/orientated non-smoking residents, as determined by their last MDS assessment, also received communication from the Executive Director and the Social Services Director on 11/22-11/23/11 verifying they are aware of the change in smoking times that took affect in October, 2011. **How the corrective action(s) will be monitored to ensure the**	

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	B indicated he did not understand the change, since everyone agrees the smoking times are insufficient. Resident B then called for a vote by the seven residents in the smoking hut, and all indicated the number of smoke times was insufficient. Resident C indicated some smokers would like to smoke before breakfast. The Activities Assistant indicated the change in smoking times was the idea of the previous Executive Director (ED) and had taken place before the current ED started on the job. During interview completed on 11/15/11 at 2:20 p.m., the ED indicated facility policy related to smoking is not at the corporate level, but at the facility level. The ED indicated the previous ED and previous Director of Nursing Services had determined the need to decrease the number of smoke times. He indicated the change had occurred prior to the end of September 2011. He indicated the Resident Council was involved in the change. During interview completed on 11/15/11 at 2:45 p.m., the SSD indicated two families had complained to the previous ED about the cost of smoke breaks. The SSD indicated some residents buy their own cigarettes, and some families supply cigarettes. The SSD indicated she		**deficient practice will not recur:** · All future policy changes will be communicated orally at least thirty days in advance through Resident Council. · Additionally, written communication will occur at least thirty days in advance to resident's Responsible Parties as well as to all residents deemed alert/orientated secondary to their last MDS assessment. **Compliance date: November 23, 2011**	

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	attended the Resident Council Meeting on the first Friday of September 2011 and told the residents about the new times for smoke breaks and told them all residents would need to wear smoking aprons. The SSD indicated the "smokers were not too unhappy." The SSD indicated she talked to residents about how much money they were spending on cigarettes. The SSD indicated the change in smoking times took place on October 3rd or 4th. The SSD named eleven residents in the facility who were smokers: Residents B, C, D, H, I, J, K, L, M, N, and O. The ED provided copy of the September 2, 2011, Resident Council Minutes on 11/15/11 at 2:50 p.m. Review of the Minutes indicated Residents H, L, O, and C were at the Resident Council Meeting. Other smokers identified by the SSD were not listed as attending the meeting. The section for "New Business" indicated, "Social Services - Issued the new times on smoke breaks, wearing aprons (all residents now)." During interview on 11/15/11 at 3:40 p.m., the ED indicated a letter including information about the change in smoking times had been sent to families, but he did not know if the letter had been sent to residents. The ED provided copy of a letter he indicated had been retrieved from			

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	the computer files of the previous ED. Review of the letter indicated related to the smoking times, "August 30, 2011, Dear Resident and/or Family member:...There has been a review of policies in relation to smoking and environmental services. It is our focus to always keep the health and well-being as well as the safety of our residents in mind. With that said, the smoking times will be changing starting Sept 30th 2011....If you would like to review the new smoking and personal values policies, please feel free to stop by the facility and ask for social services or administration...." At this same time the ED reviewed the facility's current Admissions Packet provided by the Admissions-Marketing Director. The packet included, but was not limited to, the facility's Smoking Policy, with a revision date of 10/2011. The Smoking Policy indicated, "Designated Smoking Times Designated Area Only: 8:30 a.m., 10:30 a.m., 1:00 p.m. on week-ends, 1:30 on weekdays, 3:30 p.m., 6:30 p.m., 8:30 p.m., and 10:30 p.m." The ED indicated new residents had been receiving this information but it was "wrong" and needed to be changed. During interview on 11/15/11 at 4:10 p.m., Resident E indicated she had not received a letter mentioning the smoking policy. Resident E indicated she was not			

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	a smoker so the change did not affect her. During interview on 11/15/11 at 4:45 p.m., Resident B indicated residents were told ahead of time that smoking times would be changing but the actual smoking times were not posted until the change took place. Resident B indicated he did not receive a letter advising him of a change in the smoking policy. This federal tag is related to Complaint IN00099666. 3.1-4(a)			

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F0159 SS=D	Upon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in paragraphs (c)(3)-(8) of this section. The facility must deposit any resident's personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund. The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. The individual financial record must be available through quarterly statements and on request to the resident or his or her legal representative. The facility must notify each resident that receives Medicaid benefits when the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act;			

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	and that, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI. Based on record review and interview, the facility failed to ensure residents whose personal trust funds were managed by the facility received quarterly statement of accounts for 3 of 3 residents interviewed related to personal trust funds in a sample of 14 residents. (Residents E, F, and G) Findings include: On 11/15/11 at 11:15 a.m., the Director of Nursing Services provided a list of facility residents who were interviewable. Review of the list indicated the following residents were interviewable: Residents E, F, and G. 1. During interview completed on 11/15/11 at 12:45 p.m., Resident F indicated she had to go the facility's business office and talk to [name of Interim Business Office Manager] to go over the last statement of her personal trust account when she had asked for cash from her personal trust fund "at the front desk" but the money she requested was not available. Resident F indicated in late October or early November 2011 she had not received a quarterly statement but reviewed her trust fund information	F0159	**F 159 Facility Management of Personal Funds** It is the practice of this provider to ensure that the financial statement of a resident's personal account be made available via quarterly statements, and when requested by the resident or legal representative. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · Resdinet E, F and G received a resident trust statement provide the Business Office Manager and/or the Business Assistant, for the months of July, August and September, 2011. Each resident signed verifying the have received their third quarter statement. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken.** · All residents that have a current resident trust account received, and signed, a statement	11/29/2011

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	through September 2011 with the Interim Business Office Manager. Resident F indicated she had expected a deposit of $100, which had not been deposited to her account. Resident F indicated a check for $100 for her was found located in the drawer of the "Secretary/Treasurer" for the facility. 2. During interview completed on 11/15/11 at 4:10 p.m., Resident E indicated she was admitted to the facility in March 2011 and had not received a statement related to her personal trust fund until she requested it. Resident E indicated this facility does not hand the statements out to residents every three months, unlike the long term care facility where she previously lived. Resident E located her personal trust fund statement on her desk. The statement indicated transactions in her account from 3/1/11 through 10/13/11. Resident E indicated the statement had been provided when she requested it from the Business Office on 10/13/11. Resident E pointed out a concern related to beauty shop charges in July 2011. She pointed to the charges of $34.00 on 7/1/11 and $36.00 on 7/14/11. Resident E indicated she had not had these services at the beauty shop. Resident E indicated she had talked with the beautician who agreed she had not had the services and with the Interim Business		for the months of July, August and September of 2011 (third quarter). The statements were provided by the Business Office Manager and/or Business Assistant on 11/22, 11/23, or 11/29/11. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All future quarterly statements will be sent to resident and/ or the legal representative within thirty days after the end of the quarter. A duplicate statements signed by the resident will be retained verifying delivery. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur:** · The Business Office Manager will report compliance to the IDT via the quarterly CQI meeting for at least two consecutive quarters. Failure to meet a 90% threshold will result in further action. **Compliance date: November 29, 2011**	

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	Office Manager and the Executive Director about these charges. Resident E indicated she had no statement to check on her personal trust fund account until she requested it. 3. During interview on 11/15/11 at 4:15 p.m., Resident G indicated she could not remember when she had an account statement for her personal trust fund. Resident G indicated it seemed like years since she had a statement. During interview completed on 11/15/11 at 1:20 p.m., Office Staff #1 indicated she would provide a list of residents for whom the facility managed personal trust funds. Review of the list indicated the facility managed funds for Residents E, F, and G. During interview on 11/15/11 at 4:20 p.m., the Executive Director (ED) indicated he had received no complaints from families about not receiving quarterly personal trust fund statements. The ED indicated when a resident says a statement has not been received, a statement is printed for the resident. During interview on 11/15/11 at 5:10 p.m., the ED indicated the facility has no policy related to personal trust fund accounts. At this time, the ED provided			

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	copy of the facility's Resident Trust Authorization, which he indicated the resident or responsible party signs regarding choice of a Resident Trust Fund. Review of the Resident Trust Authorization indicated, "...A quarterly financial statement is provided for each account. The quarterly financial statement is prepared in a clear and understandable format...." This federal tag relates to Complaint IN00099666. 3.1-6(g)			
F0242 SS=D	The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on observation, record review and	F0242	**F 242 Self-determination –**	11/29/2011

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	155697	A. BUILDING 00 B. WING	11/15/2011

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	interview, the facility failed to ensure the resident had a choice about having a microwave oven in the resident's room. The facility removed the microwave oven from resident's room before individually assessing and planning for the needs of the resident related to the microwave oven. The deficient practice affected 1 of 1 resident who reported his microwave oven was removed from his room in a sample of 14 residents. (Resident B) Findings include: On 11/15/11 at 11:15 a.m., the Director of Nursing Services provided a list of facility residents who were interviewable. Review of the list indicated Resident B was interviewable. During interview on 11/15/11 at 4:45 p.m., Resident B indicated during his first four or five days at the facility, he had a microwave oven in his room. He indicated a resident who was discharged from the facility had given him a microwave oven and a refrigerator. Resident B gestured toward the place on a cabinet where the microwave had sat. Observation at this time indicated a refrigerator was present in Resident B's room. Resident B indicated (name of previous Executive Director) had removed the microwave oven from his		**Right to make choices.** It is the practice of this provider to ensure that the resident has the right to request usage of all applicable equipment not prohibited by regulation or via the signed addmission policy. **What corrective action(s) will be accomplished for those residents found to have been affected by the alleged deficient practice?** · On 11/23/11a Physical Therapy Assistant assessed Resident B**'s** ability to safely use a microwave via the facility's "Microwave Skills Test Screen" form. Resident B successfully completed the assessment. Resident B acquired a micorwave on 11/23/11 for use in his room. **How will you identify other residents having the potential to be affected by the same alleged deficient practice and what corrective action will be taken** · An audit of the grievance log for the period 6/1-10/1/11 was completed by the Executvie Director on 11/23/11 to ensure no outstanding requests for microwave usage existed. **What measures will be put into place or what systemic changes you will make to**	

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	room and put it in the kitchen. Resident B indicated he was told he "had to get qualified by therapy" to use the microwave oven. Resident B indicated he had not "taken the test." Resident B indicated he was working with therapy and had asked about being tested three times but the request "fell on deaf ears." During interview on 11/15/11 at 5:05 p.m., the Dietary Manager indicated Resident B never actually had a microwave oven in his room, but another resident had given him a microwave when the other resident was discharged. The Dietary Manager indicated she was holding the microwave for Resident B, and would give it to him when he left the facility. During interview on 11/15/11 at 3:40 p.m., the Executive Director (ED) indicated a letter that included information about the changes in facility policies had been sent to families, but he did not know if the letter had been sent to residents. The ED provided copy of a letter he indicated had been retrieved from the computer files of the previous ED. Review of the letter indicated related to microwave ovens, "August 30, 2011, Dear Resident and/or Family member:...per our current policy, residents have the right to retain personal clothing and belongings as		**ensure that the alleged deficient practice does not recur** · Effective 11/28/11, a new policy is implemented that no new admitted resident will be allowed the use of microwave in his or her room. This information is now included in the admission packet. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur? i.e., what quality assurance program will be put into place** · A monthly audit of new admitted resident's room after 11/28/11 will be conduct by the Maintenance Director and reported monthly for six months to the IDT via the monthly CQI meeting verifying microwaves are not in newly admitted resident's rooms. **Compliance date: November 29, 2011**	

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	space permits, so long as such possessions do not infringe upon the rights of others or cause a health or safety hazard. This means that the following items will no longer be approved: plug-in cooking devices such as but not limited to microwaves...." The ED indicated although the letter said microwaves would be removed from resident rooms, that had not happened and residents were still being allowed to have microwaves in their rooms after they were assessed for safe use. On 11/15/11 at 5:30 p.m., the ED provided copy of a "Microwave Skills Test Screen," which he indicated therapy would use to screen residents for safe use of microwave ovens. Review of the form indicated an instruction, "This screen is to be completed and turned into the facility IDT [Interdisciplinary Team] for review." The clinical record for Resident B was reviewed on 11/15/11 at 1:50 p.m. The record indicated the resident was admitted to the facility on 8/8/11. The record included no Personal Inventory Sheet of the resident's belongings at the time of admission and no "Microwave Skills Test Screen." During interview on 11/15/11 at 5:55 p.m., the Medical Records Director			

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	indicated the record included no Personal Inventory Sheet. During the Exit Conference on 11/15/11 at 6:30 p.m., the ED indicated Resident B's microwave oven was being replaced in his room, and the resident would be screened the following day for safety in use of the microwave oven. This federal tag is related to Complaint IN00099666. 3.1-3(u)(3)			